



ORAL SURGERY + ORTHODONTICS

WELCOME TO OUR PRACTICE

Welcome to NCOSO where Your beautiful smile is our passion!

We would like to thank you for allowing us to treat you or your loved one as our patient and we are pleased to meet your oral surgery + orthodontic dental needs. We will always do our best to give you the most up-to-date and professional care available! Here is a list of our office policies and procedures:

If you or your child have active tuberculosis, persistent cough (greater than a 3-week duration, a cough that produces blood, or been exposed to anyone with tuberculosis please stop and return this form to the receptionist.

- As a courtesy, North Carolina Oral Surgery + Orthodontics (NCOSO) will file your dental claim with your insurance company. Your deductible and co-pay, or any portion not covered by your insurance company, is due at the time of service. For those patients without insurance coverage, you will be responsible for your payment in full on the day of treatment.
Broken appointments are very costly and inconvenient. If you are unable to keep your appointment, please inform us at least twenty-four (24) hours in advance for orthodontic appointments and 3 business days for surgical procedures. Two or more broken appointments will lead to you and your family being dismissed from our practice. An unconfirmed appointment may run the risk of being rescheduled.
If you have Medicaid, you must have your current Medicaid card with you. Also, if you are twenty-one (21) years of age or older you are responsible for the \$3.00 co-pay. If you do not have a current card, we reserve the right to reschedule your appointment.
If you are more than fifteen (15) minutes late for your appointment, you may be rescheduled for another day. This will be considered a broken appointment and could result in a \$25 fee (or \$100 fee for oral surgery).
All patients under the age of eighteen (18) are required to have a parent or legal guardian present with them at each appointment. They will not be seen or treated in the absence of a parent or legal guardian without a signed consent form, see page 3.
In the event your payment is past due, you are responsible to pay the cost of collecting any debt owed on your account. This includes all attorney's fees, late fees, and interest to be charged at one percent per month.

I've been given the opportunity to read the Notice of Privacy Practices. Your cooperation is greatly appreciated in this matter. If you have any questions, please feel free to ask our staff and as always thank you for choosing NCOSO!

Signature of Patient or Responsible Party Date
Office Only: We were unable to obtain written acknowledgement of receipt of Privacy Practices because:
An emergency existed, and a signature was not possible at the time. The individual refused to sign.
A copy was mailed with a request for a signature. Other:
Name: Signature: Date:

Name of Patient: Date of Birth:
NC Oral Surgery + Orthodontics is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Patient Signature:

Table with 2 columns: Entity to Receive Information, Description of information to be released. Rows include Voice Mail, Spouse, Parent, Other and Results of lab tests/x-rays, Other, Financial, Medical as follows.

How did you select NC Oral Surgery + Orthodontics (NCOSO)?

- Please select the option that applies:
Family Member/Friend Referral, Dentist Referral, Accepts My Insurance, Inter-Office Transfer, NCOSO.com (website), Google Search, Yahoo! Search, Bing Search, YP.com, Google Maps, Newspaper/Magazine, Phone Book, Open House, Mail Flyer, Office Appearance/Exterior, Fair/Festival - Which one?

Patient Information & Medical History



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+ ORTHODONTICS**

Your beautiful smiles our passion!

Patient Information

Name of Child:			Date of Birth:	
Last	First	MI		
Address:		City:	State:	Zip:
Social Security Number:		Sex:	Age:	Race:
		Weight:		
Mother's/Guardian Name:		Social Security Number:		
Address:		City:	State:	Zip:
Primary Phone Number:		Secondary Phone Number:		Email:
Father's/Guardian Name:		Social Security Number:		
Address:		City:	State:	Zip:
Primary Phone Number:		Secondary Phone Number:		Email:

Responsible Party

Name:			Relationship:		Phone:	
Last	First	MI			()	
Address:			City:	State:	Zip:	
Date of Birth:		Employer:	Social Security:		Driver's License Number:	
Circle Method of Payment:		Cash	Visa/MC	Check	Insurance	Other

Insurance

Name of Insured:		Date of Birth:		Relationship to Patient:		Social Security:	
Employer:		Insurance Company:					
Address:			City	Zip	Phone:		()
Group Number:		Policy Number:					

If you have additional dental insurance, please notify our staff.

Dental Insurance

As a courtesy, we will be happy to file your insurance claims as well as obtain all plan information and provisions. It is our pleasure to assist you with this; however, we encourage you to become familiar with your coverage and benefit period allowances. We strive to assist you in utilizing and maximizing your coverage and recommend that you also maintain knowledge of your benefits used throughout the benefit period.

Please understand that your insurance is a contract between you, your employer, and your insurance company. Thus, we cannot speak on behalf of your insurance company. We will gladly act as your advocate, but we cannot be responsible for settling any disputed claims or coverage. We thank you for choosing us to provide excellent dental care for you, and we look forward to taking care of your dental needs.

If we do not receive payment from your insurance carrier **within forty-five (45) days**, we will notify you. Failure of your insurance carrier to reimburse our office **within sixty (60) days** will result in our billing you directly for the remaining balance. **Please remember that you are ultimately responsible for your bill.**

Signature of Patient or Responsible Party _____

Date _____

Health History: Please answer the following questions in regard to your child.

Has the child had any history of, or conditions related to, any of the following:

- | | | | | | |
|---|--|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV + / AIDS | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tobacco/Drug Use |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Kidney | <input type="checkbox"/> Pregnancy (Teens) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hearing | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Liver | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Sickle cell | <input type="checkbox"/> |

Child's Physician
Name: _____

Phone:
() _____

Medical Information

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____			
Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How would you describe the child's eating habits? _____			
Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have a history of any illnesses? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever received a general anesthetic?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any inherited problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any speech difficulties?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had a blood transfusion?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the child physically, mentally, or emotionally impaired?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child experience excessive bleeding when cut?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the child currently being treated for any illnesses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problem with dental treatment in the past?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had dental radiographs (x-rays) exposed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever suffered any injuries to the mouth, head or teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problems with the eruption or shedding of teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What type of water does your child drink? <input type="checkbox"/> City Water <input type="checkbox"/> Well Water <input type="checkbox"/> Bottled Water <input type="checkbox"/> Filtered Water			
Does the child take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride toothpaste used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child suck his/her thumb, fingers or pacifier?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At what age did the child stop bottle feeding? Age _____ Breast Feeding? Age _____			
Does the child participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parental Consent

I request and authorize NC Oral Surgery + Orthodontics to perform the treatment and procedures outlined on treatment plan for:

I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary and/or advisable by the clinical faculty to diagnose and/or treat the patient's dental needs.

- I have had explained to me, and I have had sufficient opportunity to discuss the patient's dental condition and needs, the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
- The usual and most frequently occurring risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain and/or discomfort during the following treatment swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, and allergic reactions.
- I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to, or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient will receive.
- I understand that at North Carolina Oral Surgery + Orthodontics that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. We will provide a clinical environment that is likely to help children to learn to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation, and demonstration of procedures and instruments, using variable voice tone and loudness.
- I understand that should the patient become uncooperative during dental procedures with movement of the head, arms, and/or legs, dental treatment cannot safely be provided. During such disruptive behavior, it may be necessary for the assistant to hold the patient's hands, stabilize the head, and/or control leg movements. If we still cannot provide treatment, we will reschedule the patient.
- All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.
- I understand that I may revoke this consent, in writing at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
- I confirm that I have read and understand this form, or it was read to me, and that all blanks were filled and all inapplicable paragraphs, if any, were stricken prior to my signing below.
- If anyone other than yourself, legal guardian, is allowed to bring your child to their dental visit please list name & relationship:

Name

Relationship to Patient

Signature of parent, legal guardian, or care taker

Date

Printed Name

Date

Witness

Date

